

March 25, 2020

To the Medical Staff of Renown Regional Medical Center:

This communication is to address upcoming changes in the ability of the surgeons and interventionalists to schedule cases at Renown Regional Medical Center. After careful consideration, the Surgical Services Executive Committee (SSEC), the COVID-19 Review subcommittee of the SSEC, Renown Regional Medical Center Administration, and the Chiefs of Staff at both Renown Regional Medical Center and Renown South Meadows Medical Center are implementing a change to the surgical scheduling process. In conjunction with recommendations from the American College of Surgery (ACS), Centers for Medical and Medicaid Services (CMS), the Society of Surgical Oncology (SSO), the Nevada State Medical Association, and other professional societies, the following process will be put in place:

1. As of Tuesday, March 31, 2020, at 0001 in the morning, all cases that are not urgent or emergent will be indefinitely postponed. This includes all previously scheduled elective non-optional cases that have not been evaluated and approved by the Covid-19 Review subcommittee after Tuesday, March 25, 2020.
2. Each surgeon or interventionalist that feels his or her elective non-optional case meets the criteria included in the attachments accompanying this e-mail will be able to submit a request for that case to be scheduled to the surgery scheduling office at Renown, using the form titled "Surgery Scheduling Form/ Submission for Covid Review Team." This is available at surgery scheduling and can be obtained in the same fashion the surgery scheduling form has been obtained by the scheduling offices in the past.
3. In addition to the Surgery Scheduling Form/ Submission for COVID-19 Review Team, **it is required that the surgeon or interventionalist submit evidence of medical necessity, including objective criteria to support not postponing each individual case.** This must conform to guidelines accompanying this e-mail, and the documentation will be reviewed daily by the COVID-19 Review subcommittee. It is the initial goal that the review can be completed three days prior to the requested surgical date. Eventually, the goal is to complete this review seven days prior to the requested surgical date.

This decision was made with great consideration as we understand this change will affect surgeons' and interventionalists' ability to practice and is likely to cause financial hardship. The reasons for this change include, but are not limited to, the following:

1. According to the best available data, our infection rate, hospitalization rate, and utilization of resources are currently and for the near future sharply increasing. The ability to provide PPE and other vital resources to our providers and employees must be given highest priority if we are to be able to provide care to our community in the coming weeks.

2. While the vast majority of surgeons and interventionalists have made responsible decisions about delaying cases, all of the providers must be held to the same standards or we risk losing the majority who are acting in a responsible manner despite great personal cost.

This change in the scheduling process does not mean that all elective non-optional cases will be cancelled, but does ensure that they will be done appropriately. It is likely that further changes to our ability to schedule cases will occur as the COVID-19 situation continues to evolve.

Email attachments:

- Surgery Scheduling Form/ Submission for Covid-19 Review Team
- Covid-19: Guidance for Triage of Non-Emergent Surgical Procedures
- CMS Adult Elective Surgery and Procedures Recommendations
- Society of Surgical Oncology Recommendations

Again, I understand this is a very difficult change, and I would emphasize that these measures are being undertaken with deep consideration to how they will affect our providers, the people who work in their offices, and our community. Further information will be disseminated at a planned teleconference to be held for the surgery section chiefs, as well as the interventionalist section chiefs or department chairs, to be scheduled for Thursday, March 26.

ACS has sent out updated guidelines as this letter is being written and sent, and those guidelines will be reviewed and incorporated into this process. These most recent guidelines can be found at <https://facs.org/covid-19/clinical-guidance/elective-case>.

Sincerely,

Bob Nachtsheim M.D.

Chief of Staff, Renown Regional Medical Center

Bret Frey

Chief of Staff, Renown South Meadows Hospital



Surgery Scheduling Fax Form/Submission for COVID Review Team

Renown Surgery Scheduling Office Fax: 775-982-4281

Surgery Location: ___ Tahoe Tower ___ Roseview (Same Day Surgery) ___ Vascular OR ___ Renown Regional ENDO
___ Renown South Meadows ___ Renown L & D

Surgery Date: _____ **Time:** _____ **TF** _____ **Cancel** _____ **Reschedule to:** _____

Patient Status (*Physician order must specify status*): ___ **Inpatient** ___ **Outpatient**

Surgeon: _____ **Assistant:** _____

Procedure (*Please Specify Vessel/Body Part/Side*): _____ **Length of Procedure** _____

Medical Necessity Reason with objective criteria to support not postponing:

Diagnosis: _____

CPT Code(s): _____

ICD-10 Code(s): _____

Special Equipment (*Please check all that apply*): ___ N/A ___ Fluoro ___ Laser ___ Cell Saver ___ OSI ___ Evok/SSEP ___ Nav Probe
___ Robot ___ Ultrasound ___ Stealth ___ Landmark ___ Somnus ___ IONM Specialty Care ___ Other: _____

Name of Vendor/ Company notified: _____ N/A _____

Patient Name: _____

SSN: _____ **DOB:** _____ **Gender:** ___ Male ___ Female

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

(Please provide at least one contact number)

Address: _____

Patient's Preferred Language: ___ English ___ Spanish ___ Other: _____

Special Needs (*Please check*): ___ N/A ___ Prisoner ___ Pregnant ___ Isolation ___ W/C ___ Walker ___ Gurney
___ Total Lift ___ Para/Quadraplegic ___ Trach ___ Other: _____

History of (*Please check*): ___ MRSA ___ VRE ___ C. Diff ___ None Known

Guarantor Name: _____ **Subscriber Name** (*if different*): _____

Insurance: _____ **Insurance ID#:** _____

Authorization #: _____ **# Days:** _____

Name of Legal Guardian (*or N/A*): _____ **SSN:** _____ **DOB:** _____

Guardian/Power of Attorney contact (*or N/A*): _____ **Contact Phone:** _____

Transfer from Care Center (*Name of Care Center or N/A*): _____ **Phone:** _____

Scheduled by: _____ **Date/Time:** _____



COVID-19: Guidance for Triage of Non-Emergent Surgical Procedures

Online March 17, 2020

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In response to the rapidly evolving challenges faced by hospitals related to the Coronavirus Disease 2019 (COVID-19) outbreak, and broad calls to curtail “elective” surgical procedures, the American College of Surgeons (ACS) provides the following guidance on the management of non-emergent operations.

It is not possible to define the medical urgency of a case solely on whether a case is on an elective surgery schedule. While some cases can be postponed indefinitely, the vast majority of the cases performed are associated with progressive disease (such as cancer, vascular disease and organ failure) that will continue to progress at variable, disease-specific rates. As these conditions persist, and in many cases, advance in the absence of surgical intervention, it is important to recognize that the decision to cancel or perform a surgical procedure must be made in the context of numerous considerations, both medical and logistical. Indeed, given the uncertainty regarding the impact of COVID-19 over the next many months, delaying some cases risks having them reappear as more severe emergencies at a time when they will be less easily handled. Following careful review of the situation, we recommend the following:

Hospitals and surgery centers should consider both their patients’ medical needs, and their logistical capability to meet those needs, in real time.

The medical need for a given procedure should be established by a surgeon with direct expertise in the relevant surgical specialty to determine what medical risks will be incurred by case delay.

Logistical feasibility for a given procedure should be determined by administrative personnel with an understanding of hospital and community limitations, taking into consideration facility resources (beds, staff, equipment, supplies, etc.) and provider and community safety and well-being.

Case conduct should be determined based on a merger of these assessments using contemporary knowledge of the evolving national, local and regional conditions, recognizing that marked regional variation may lead to significant differences in regional decision-making.

The risk to the patient should include an aggregate assessment of the real risk of proceeding and the real risk of delay, including the expectation that a delay of 6-8 weeks or more may be required to emerge from an environment in which COVID-19 is less prevalent.

In general, a day-by-day, data-driven assessment of the changing risk-benefit analysis will need to influence clinical care delivery for the foreseeable future. Plans for case triage should avoid blanket policies and instead rely on data and expert opinion from qualified clinicians and administrators, with a site-specific granular understanding of the medical and logistical issues in play. Finally, although COVID-19 is a clear risk to all, it is but one of many competing risks for patients requiring surgical care. Thus, surgical procedures should be considered not based solely on COVID-associated risks, but rather on an assimilation of all available medical and logistical information.

To further assist in the surgical decision-making process to triage non-emergent operations, ACS suggests that surgeons look at the Elective Surgery Acuity Scale (ESAS) from St. Louis University (below). Each surgical specialty has specific guidelines that are pertinent to the procedures within that specialty. We gratefully acknowledge and thank Allan Kirk, MD, PhD, FACS, and Sameer Siddiqui, MD, FACS, for their contributions and recommendations to this document.

ACS will continue to follow up with additional recommendations and refinements, as needed.

Elective Surgery Acuity Scale (ESAS)

Tiers/Description	Definition	Locations	Examples	Action
Tier 1a	Low acuity surgery/healthy patient Outpatient surgery Not life threatening illness	HOPD ASC Hospital with low/no COVID- 9 census	Carpal tunnel release Penile prosthesis EGD Colonoscopy	Postpone surgery or perform at ASC
Tier 1b	Low acuity surgery/unhealthy patient	HOPD ASC Hospital with low/no COVID-19 census		Postpone surgery or perform at ASC
Tier 2a	Intermediate acuity surgery/healthy patient Not life threatening but potential for future morbidity and mortality. Requires in hospital stay	HOPD ASC Hospital with low/no COVID-19 census	Low risk cancer Non urgent spine Ureteral colic	Postpone surgery if possible or consider ASC
Tier 2b	Intermediate acuity surgery/unhealthy patient	HOPD ASC Hospital with low/no COVID-19 census		Postpone surgery if possible or consider ASC
Tier 3a	High acuity surgery/healthy patient	Hospital	Most cancers Highly symptomatic patients	Do not postpone
Tier 3b	High acuity surgery/unhealthy patient	Hospital		Do not postpone

HOPD – Hospital Outpatient Department

ASC – Ambulatory Surgery Center

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CMS Adult Elective Surgery and Procedures Recommendations:

Limit all non-essential planned surgeries and procedures, including dental, until further notice

To aggressively address COVID-19, CMS recognizes that conservation of critical resources such as ventilators and Personal Protective Equipment (PPE) is essential, as well as limiting exposure of patients and staff to the SARS-CoV-2 virus. Attached is guidance to limit non-essential adult elective surgery and medical and surgical procedures, including all dental procedures. These considerations will assist in the management of vital healthcare resources during this public health emergency.

Dental procedures use PPE and have one of the highest risks of transmission due to the close proximity of the healthcare provider to the patient. To reduce the risk of spread and to preserve PPE, we are recommending that all non-essential dental exams and procedures be postponed until further notice.

A tiered framework is provided to inform health systems as they consider resources and how best to provide surgical services and procedures to those whose condition requires emergent or urgent attention to save a life, preserve organ function, and avoid further harms from underlying condition or disease. Decisions remain the responsibility of local healthcare delivery systems, including state and local health officials, and those surgeons who have direct responsibility to their patients. However, in analyzing the risk and benefit of any planned procedure, not only must the clinical situation be evaluated, but resource conservation must also be considered. These recommendations are meant to be refined over the duration of the crisis based on feedback from subject matter experts. At all times, the supply of personal protective equipment (PPE), hospital and intensive care unit beds, and ventilators should be considered, even in areas that are not currently dealing with COVID-19 infections. Therefore, while case-by-case evaluations are made, we suggest that the following factors to be considered as to whether planned surgery should proceed:

- Current and projected COVID-19 cases in the facility and region.
 - consider the following tiered approach in the table below to curtail elective surgeries. The decisions should be made in consultation with the hospital, surgeon, patient, and other public health professionals.
- Supply of PPE to the facilities in the system
- Staffing availability
- Bed availability, especially intensive care unit (ICU) beds
- Ventilator availability
- Health and age of the patient, especially given the risks of concurrent COVID-19 infection during recovery
- Urgency of the procedure.

Tiers	Action	Definition	Locations	Examples
Tier 1a	Postpone surgery/procedure	Low acuity surgery/healthy patient- outpatient surgery Not life threatening illness	HOPD* ASC** Hospital with low/no COVID-19 census	-Carpal tunnel release -EGD -Colonoscopy -Cataracts
Tier 1b	Postpone surgery/procedure	Low acuity surgery/unhealthy patient	HOPD ASC Hospital with low/no COVID-19 census	-Endoscopies
Tier 2a	Consider postponing surgery/procedure	Intermediate acuity surgery/healthy patient- Not life threatening but potential for future morbidity and mortality. Requires in-hospital stay	HOPD ASC Hospital with low/no COVID-19 census	-Low risk cancer -Non urgent spine & Ortho: Including hip, knee replacement and elective spine surgery -Stable ureteral colic -Elective angioplasty
Tier 2b	Postpone surgery/procedure if possible	Intermediate acuity surgery/unhealthy patient-	HOPD ASC Hospital with low/no COVID-19 census	
Tier 3a	Do not postpone	High acuity surgery/healthy patient	Hospital	-Most cancers -Neurosurgery -Highly symptomatic patients
Tier 3b	Do not postpone	High acuity surgery/unhealthy patient	Hospital	-Transplants -Trauma -Cardiac w/ symptoms -limb threatening vascular surgery

*Hospital Outpatient Department

** Ambulatory Surgery Center

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Cancer Surgeries in the Time of COVID-19: A Message from the SSO President and President-Elect

March 23, 2020



Dear SSO Members,

In these unprecedented times, we are forced to consider triage and rationing of cancer surgery cases. Here are a few of the reasons:

- the potential shortage of supplies, such as masks, gowns, gloves
- the potential shortage of hospital personnel due to sickness, quarantine and duties at home
- the potential shortage of hospital beds, ICU beds and ventilators
- the desire to maximize social distancing amongst our patients, colleagues and staff.

We have asked each of the SSO Disease Site Work Group Chairs and Vice Chairs to provide their recommendations for managing care in their specialties, assuming a 3- to 6-month delay in care. We have summarized their recommendations below.

Numerous organizations are publishing in-depth guidelines, such as the NCCN, ACS, and ASCO, and we will provide links to those documents on the [SSO Website](#). We have also instituted a COVID-19 community discussion page in [My SSO Community](#) for members to share what is happening in their institutions. In the next few days, SSO will produce a series of podcasts featuring discussions with experts, regarding their opinions and institutional practices. These podcasts will be available on [SSO's Website](#), iTunes, Stitcher and other podcast platforms. Please watch your email and SSO's [Twitter](#) and [Facebook](#) pages for details. The [Annals of Surgical Oncology](#) will be publishing an editorial on this topic soon.

As each institution across the world is experiencing this pandemic at different levels, the timing of rationing care will vary and must be decided locally. **The recommendations below represent generalized opinions from experts in their fields, but decisions must be made on a case-by-case basis** based upon your knowledge and understanding of the biology of each cancer, alternative treatment options, and how restrictive your institution is at the time the patient will be scheduled for surgery.

As conditions evolve, the SSO will provide updated information. It is encouraging to see how SSO leadership, committees, members and staff have eagerly reached out to help in response to this pandemic. The SSO office is being run remotely at this time, as Chicago is under a state-wide stay-at-home order. Our dedicated staff, however, are available to address questions or issues that arise at info@surgonc.org.

We wish you the best in these challenging times.

David L. Bartlett, MD
SSO President

James R. Howe, MD
SSO President-Elect

Breast Cancer

Defer surgery for at least 3 months for atypia, prophylactic/risk reducing surgery, reconstruction and benign breast disease.

DCIS

- Defer for 3-5 months
- Treat ER+ DCIS with endocrine therapy
- Monitor monthly for progression
- Untreated DCIS high priority for surgery when safe/ORs available

ER+ invasive breast cancer (Stage I-III)

- Treat with endocrine or chemotherapy in a neoadjuvant fashion as deemed appropriate by multidisciplinary tumor board recommendations

Triple negative/HER2+ invasive breast cancer

- Treat with neoadjuvant chemotherapy for T2+ and/or N1+ disease
- Consider primary surgery as urgent if patient unable to undergo chemotherapy or tumor is small and surgical information could inform chemotherapy decisions.

Post-neoadjuvant chemotherapy

- Delay post-chemotherapy surgery for as long as possible (4-8 week window) in those patients for whom adjuvant systemic therapy is unclear/not indicated.

Unusual Cases/surgical emergencies/special considerations

- Patients with progressive disease on systemic therapy, angiosarcoma and malignant phyllodes tumors should be considered for urgent surgery and should not be delayed.

Colorectal Cancer

- Defer surgery for all cancers in polyps, or otherwise early stage disease.
- Operate if obstructed (divert only if rectal) or acutely transfusion dependent.
- Proceed with curative intent surgery for colon cancer.
- Consider all options for neoadjuvant therapy including utilization of TNT for rectal cancer and to consider neoadjuvant chemotherapy for locally advanced colon cancer
- Delay post-TNT rectal surgery for 12 to 16 weeks.
- Utilize 5x5 Gy pelvic radiotherapy and defer further surgery for locally advanced rectal cancer patients.

Endocrine/Head and Neck Cancer

Most uncomplicated endocrine operations can be delayed.

Diseases and presentations that might qualify for more urgent surgery (i.e., within approximately 4-8 weeks during the current pandemic), include:

Thyroid

- Thyroid cancer that is a current or impending threat to life, those that are threatening morbidity with local invasion (e.g., trachea, recurrent laryngeal nerve), aggressive biology (rapidly growing tumor or recurrence, rapidly progressive local-regional disease including lymph nodes)
- Severely symptomatic Graves' disease that has failed medical therapy
- Goiter that is highly symptomatic or is at risk for impending airway obstruction
- Open biopsy with diagnostic intent for suspected anaplastic thyroid cancer or lymphoma

Parathyroid

- Hyperparathyroidism with life-threatening hypercalcemia that cannot be controlled medically

Adrenal

- Adrenocortical cancer or highly suspected adrenocortical cancer
- Pheochromocytoma or paraganglioma that is unable to be controlled with medical management
- Cushing's syndrome with significant symptoms that is unable to be controlled with medical management
- Generally, functional adrenal tumors that are medically controlled and asymptomatic non-functional adrenal adenomas can be delayed

Neuroendocrine Tumors

- Symptomatic small bowel NETs (e.g., obstruction, bleeding/hemorrhage, significant pain, concern for ischemia)
- Symptomatic and/or functional pancreatic NET that cannot be controlled medically
- Lesions with significant growth or short doubling times
- Cytoreductive operations and metastasectomy should generally be delayed but should be considered on an individual basis

Upper Gastrointestinal Cancer

Most gastrointestinal cancer surgery is not elective.

Gastric and esophageal cancer

- cT1a lesions amenable to endoscopic resection should preferentially undergo endoscopic management.
- cT1b cancers should be resected.
- cT2 or higher and node positive tumors should be treated with neoadjuvant systemic therapy.
- Patients finishing neoadjuvant chemotherapy can stay on chemotherapy if responding and tolerating treatment.

Defer surgery for less biologically aggressive cancers, such as GIST unless symptomatic or bleeding.

Hepato-pancreato-biliary Cancer

Operate on all patients with aggressive HPB malignancies as indicated.

- Pancreas adenocarcinoma, gastric cancer, cholangiocarcinoma, duodenal cancer, ampullary cancer, metastatic colorectal to liver
- If responding to and tolerating neoadjuvant chemotherapy, then continue and delay surgery.

Use ablation or stereotactic radiosurgery instead of resection for liver metastases where possible.

Consider ablation or embolization over surgical resection for HCC.

Defer surgery for asymptomatic PNET, duodenal and ampullary adenomas, GIST, and high risk IPMN's, unless delay will affect resectability.

Melanoma

- Delay wide local excision of in-situ disease for 3 months and, as resources become scarce, all lesions with negative margins on initial biopsy. Efforts should be made to perform procedures in an outpatient setting to limit use of OR resources.
- Surgical management of T3/T4 melanomas (>2 mm thickness) should take priority over T1/T2 melanomas (≤2 mm thickness). The exception is any melanoma that is partially/incompletely biopsied in which large clinical residual lesion is evident. Gross complete resection is recommended in this case.
- Sentinel Lymph Node biopsy is reserved for patients with lesions > 1mm and, as resources become scarce, set aside for 3 months.
- Manage clinical Stage III disease with neoadjuvant systemic therapy. If resources permit and patient is not suitable for systemic therapy, consider resection of clinical disease in an outpatient setting.
- Metastatic resections (stages III and IV) should be placed on hold unless the patient is critical/symptomatic or unresponsive to systemic therapies (assuming surgical resources are available).

Peritoneal Surface Malignancy

- Operate on patients with malignant bowel obstruction if a palliative procedure is feasible.
- As CRS/HIPEC can take unique levels of resources, special consideration should be made for proceeding with these cases.
- Defer CRS/HIPEC for low grade appendiceal mucinous neoplasms except in extreme circumstances
- Consider systemic chemotherapy for peritoneal metastases from high grade appendix cancer, gastric cancer, colorectal cancer, high grade mesothelioma, ovarian cancer and desmoplastic small round cell tumors.

If patients are completing neoadjuvant chemotherapy and are ready for surgery, consider continuing chemotherapy if responding and tolerating therapy. For those who cannot continue neoadjuvant chemotherapy then consider delaying surgery for:

- 4-6 weeks in patients with high grade appendiceal, colorectal, mesothelioma, or ovarian cancer.
- 2 to 4 weeks in patients with gastric cancer or desmoplastic small round cell tumors.

Defer surgery for peritoneal metastases from rare low-grade malignancies such as neuroendocrine tumors and gastrointestinal stromal tumors.

Sarcoma

A primary soft tissue sarcoma without metastatic disease on staging that needs surgery will be prioritized for the OR.

- Deferring the surgical treatment of newly diagnosed truncal/extremity well-differentiated liposarcoma/ALT and desmoids for at least 3 months or more. Reassess at that time.
- Resection of other low-grade lesions with known indolent behavior (e.g., retroperitoneal well-differentiated liposarcoma) and low metastatic risk (e.g., myxoid liposarcoma, low grade-fibromyxoid tumor) can be deferred for short intervals depending on available resources.
- Consider short interval deferral of re-excision for R1 margins in extremity/truncal lesions if OR resources are limited.

If there is an indication for radiation therapy, plan to do it preoperatively (already do that anyways). This can be administered in a lower risk outpatient setting and will push out the timing of surgery for about 3-4 months.

Use of neoadjuvant therapy for high grade sarcomas or recurrent disease can be considered if it can be safely delivered in an outpatient setting as a means of deferring surgical intervention.

Active observation protocols or low-toxicity systemic options can be considered for patients with recurrent disease. Surgery for recurrent disease can be offered to patients who:

- are likely to have relatively high chances of obtaining long-term disease control in the context of complete gross resection (e.g., long disease-free interval, solitary site of recurrence)
- require immediate palliation (e.g., due to bleeding, obstruction), and
- who do not have indolent histologies (e.g., well-differentiated liposarcoma in the retroperitoneum) that can be managed with active observation.